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In The

Supreme Court of the United States

October Term, 1993

NEW JERSEY CARPENTERS WELFARE FUND, DISTRICT COUNSEL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND, LOCAL UNION 400 IBEW WELFARE FUND, TEAMSTERS LOCAL 641 WELFARE FUND, LOCAL 1245 HEALTH FUND AND LOCAL 1245 BAKERY AND SPECIALITY HEALTH FUND, SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health, et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

State laws which relate to any employer benefit plan governed under ERISA are preempted under Section 514 of ERISA, 29 U.S.C. § 1144(a), and in accordance with the Supremacy Clause of the Constitution such laws are unconstitutional. The questions raised are:

1. Is the New Jersey statutory hospital rate-setting scheme providing for added charges to fund uncompensated care, medicare shortfalls, and payor discounts, as applied to ERISA-governed welfare benefit plans and their beneficiaries, preempted by ERISA, 29 U.S.C. § 1144(a), Section 514?

2. Does the majority decision of the Court of Appeals below – holding that ERISA does not preempt a state law of general application which nevertheless refers to ERISA plans, extracts millions of dollars from ERISA plans, and is predicated on the existence of ERISA plans – conflict with decisions of the United States Supreme Court and courts in other Circuits interpreting the breadth of the preemption provision of ERISA?

PARTIES TO THE PROCEEDING BELOW

All parties to the proceeding in the Court below are set forth in the caption of the case as appearing in the opinion of the Court below and reproduced in the Appendix. (1a-61a).[1]

CORPORATE DESIGNATION OF PETITIONERS

Petitioners are unincorporated welfare funds and have no parent companies or subsidiaries.

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[1] Petitioners rely upon the Appendix already filed with the Court in this action in No. 93-115, *NYSA-ILA Welfare Fund, et al. v. Frances J. Dunston, et al.* The references noted are to the pages in that Appendix.

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Petitioners, New Jersey Carpenters Welfare Fund, District Council of Iron Workers of Northern New Jersey Welfare Fund, Local Union 400 IBEW Welfare Fund, Teamsters Local 641 Welfare Fund, Local 1245 Health Fund and Local 1245 Bakery & Specialty Health Fund, and Sheet Metal Workers Local Union No. 25 Welfare

Fund, respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit, entered on May 14, 1993.

OPINIONS BELOW

The judgment and opinion of the Court of Appeals for the Third Circuit for which review is sought is unofficially reported at 61 U.S.L.W. 2723 (3d Cir. May 14, 1993), and is reprinted in the Appendix. (1a-61a). The decision of the United States District Court, District of New Jersey is reported at 793 F. Supp. 524 (D.N.J. 1992) and has also been reprinted in the Appendix. (64a-95a).

STATEMENT OF JURISDICTION

The judgment of the Court of Appeals for which review is sought was entered on May 14, 1993. (45a). On June 15, 1993, the Court of Appeals denied petitioners' request for rehearing. However, on July 8, 1993, the Court of Appeals granted Petitioners' Motion for a Stay of the Mandate. On July 16, 1993 the Court of Appeals granted an extension of the Stay of Mandate through August 6, 1993. This Court has jurisdiction under 28 U.S.C. § 1254(a) and 28 U.S.C. § 2101(c).

CONSTITUTIONAL AND STATUTORY PROVISIONS

Article VI, Clause 2 of the United States Constitution provides in pertinent part:

> This Constitution and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the Supreme Law of the Land . . . , any thing in the Constitution or Laws of any State to the Contrary notwithstanding.

Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended and supplemented to date, 29 U.S.C. § 1144(a) provides in pertinent part:

> Except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b).

STATEMENT OF THE CASE

PROCEEDINGS

Several actions were originally brought in the United States District Court for the District of New Jersey by petitioners and other ERISA welfare funds challenging the New Jersey statutory hospital rate setting scheme as being preempted by ERISA, 29 U.S.C. § 1001 *et seq.*[2] All cases were consolidated in the District Court.

On May 27, 1992, the District Court, the Honorable Alfred Wolin, granted summary judgment in favor of

[2] In addition, the complaint alleged that the statutory scheme violated other state and federal constitutional provisions, including the Takings Clause, Equal Protection Clause, the Due Process Clause, the New Jersey Constitution's prohibition against illegal "special laws," and its prohibition against illegal delegation of taxing power.

petitioners declaring that several aspects of the New Jersey hospital billing scheme were preempted by ERISA. In its Order, the Court granted permanent injunctive relief barring the prospective enforcement of the violative statutory and regulatory provisions. (64a). The District Court's decision was stayed until June 26, 1992 to allow for the filing of an appeal and stay application to the Third Circuit.

On June 17, 1992, the Hospital Association along with various individual defendant hospitals filed a notice of appeal with the State filing a notice of appeal soon thereafter. By Order dated June 24, 1992, the Third Circuit granted a stay pending appeal and expedited the briefing schedule. On or about June 25, 1992, the Welfare Funds filed notices of cross-appeal challenging the District Court's refusal to exercise jurisdiction over the funds' claims for reimbursement of hospital bills paid under protest during the pendency of the lawsuit.

On May 14, 1993, the Court of Appeals for the Third Circuit issued a 2-1 opinion reversing the District Court's judgment. The majority held that the questioned statutory and regulatory scheme was not preempted under Section 514(a) of ERISA, 29 U.S.C. § 6, and thus was constitutional. (45a-61a).

On June 15, 1993, the Court of Appeals denied petitioners' request for panel and in banc rehearing. (62a). On July 8, 1993, the Court of Appeals granted petitioners' motion for a Stay of the Mandate through July 22, 1993 pursuant to Rule 41(b) of the Federal Rules of Appellate Procedure pending the filing of a Petition for Certiorari.

On July 16, 1993, the Court of Appeals extended the Stay of the Mandate through August 6, 1993.

THE PARTIES

Petitioners are non-profit, self-insured and self-funded employee welfare benefit funds governed by ERISA, Section 3(1), 29 U.S.C. § 1002(c)(1). Pursuant to statute, each of the Welfare Funds is administered by a joint board of union and employer trustees, and each receives employer contributions required under collective bargaining agreements. These contributions are used for the exclusive benefit of the employees and their dependents (the "participants") to provide hospital and other health and welfare coverage. Some welfare plans cover 100% of customary medical charges for hospitalization, room, board and miscellaneous charges for a maximum number of days; others provide less than full coverage. The level and type of coverage are determined by each fund's trustees. The Welfare Funds are strictly limited by their plan documents and ERISA, 29 U.S.C. §§ 1002, 1003(c)(1) and 186, to expend funds *only for the exclusive benefit of their participants*. Many of the Welfare Funds provide benefits to participants in several different states, and collectively, provide coverage to over 50,000 persons within the State of New Jersey.

The various defendant governmental entities named in this action are charged under the Act with the administration or implementation of the hospital billing scheme. Each of the defendant hospitals was required by law to charge payors and patients in accordance with the schedule of rates approved by the State. N.J. Stat. Ann.

§ 26:2H-18 (West 1987 & Supp 1992). All hospitals in New Jersey are classified as "health care facilities" which must obtain licenses in order to operate and must comply with rate procedures and schedules established by New Jersey laws.

The Hospital Association, a defendant/intervenor, is an association established to promote the concerns of acute care and specialized hospitals throughout the State of New Jersey. Each hospital in his consolidated action is a member of the Hospital Association.

THE HOSPITAL BILLING SCHEME

The questioned rate structure was established pursuant to the New Jersey Health Care Facilities Planning Act (the "Planning Act"),[3] as amended and supplemented by the Health Care Cost Reduction Act (the "Reduction Act"), N.J. Stat. Ann. § 26:2H-1 *et seq.* (West 1987 & Supp. 1992) (collectively, the "Act"), as well as the regulations promulgated thereunder, N.J. Admin. Code §§ 8:31B *et seq.* (Supp. 1990).[4]

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[3] The 1978 amendments to the New Jersey Health Care Facilities Planning Act, which establish DRG rate structures, are sometimes referred to within the hospital industry as Chapter 83.

[4] On January 1, 1993 the regulatory scheme at issue in this case was superseded by the New Jersey Legislature. However, as held by the Third Circuit the issues raised in this case are viable and are not moot. (22a). Aside from seeking a prospective injunction of the enforcement of the scheme, petitioners also seek restitution of monies paid under protest under the scheme and respondents have sought to recover payment for charges which the Welfare Funds have not paid. Since millions of dollars

Under the rate setting scheme, patients in New Jersey hospitals received bills that contain several different statements of hospital charges. Each bill contained a "Total Charges" amount which was calculated by totalling a line-by-line itemization of the cost of hospital services rendered to a given patient. The Total Charges reflect the charges incurred by each patient for the services provided to that patient, including routine overhead costs associated with hospitalization.

Each hospital bill also contained the "DRG Amount Due." This DRG amount was calculated by the hospitals in accordance with the DRG rate setting procedures established by the State. The DRG rate was selected by the hospital based upon the categorization of a patient's condition and treatment into one of 742 categories of medical conditions as defined by the Commission and the Commissioner. Each DRG category[5] was assigned a hospital-specific dollar amount which the hospital was required to charge to "purchasers of hospital services," regardless of whether the actual medical costs incurred in treatment are above or below the DRG rate. N.J. Stat. Ann. § 26:2H-18 (West 1987 & Supp. 1992); N.J. Admin.

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in charges are still at stake, the issues in this case are clearly not moot. Moreover, the Third Circuit's decision will invite other states to implement similar regulatory schemes.

[5] "Diagnostic Related Groups" represented categories of hospital inpatients with similar clinical characteristics; and, except for outliers [patients displaying atypical characteristics relative to other patients, *e.g.*, inordinately long or short lengths of stay – N.J. Admin. Code § 8:31B-3.19(9)(2)], patients in each DRG can be expected to consume similar amounts of hospital resources. N.J. Admin. Code § 8:31B-5.1(a).

Code § 8:31B-3.42. The DRG rate was designed to set a prospective rate of reimbursement for each hospital, in advance of actual treatment, which was a blend of state-wide averages of hospital resources consumed and hospital specific resources consumed in treating particular illnesses. N.J. Stat. Ann. § 26:2H-5b (West 1987 & Supp. 1992). Thus, the DRG amount due set forth on each hospital bill was not related to the actual costs incurred by the patient, but rather upon a weighted average of costs incurred in state-wide and hospital specific care for a given condition.

Although originally intended as such, the DRG charge was no longer simply a weighted average of expected medical costs for a given condition. The weighted average component (the "DRG Base Cost")[6] is a base cost upon which surcharges are added to arrive at the DRG rate. Surcharges or "add-ons" were included in the DRG rate to pay for uncompensated medical care, the

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[6] The DRG Base Cost reflects a wide variety of direct and indirect patient care costs which are calculated by the Commission based upon actual costs incurred by hospitals during a particular base year and updated yearly to account for inflation as well as various other factors reflecting average health care costs incurred by the hospitals for treating each DRG condition. N.J. Stat. Ann. § 26:2H-2k; N.J. Admin. Code §§ 8:31B-3.4 to 3.7; 8:31B-2.5; 8:31B-3.16.

Direct patient care costs include the salaries and fringe benefits provided to employees engaged in the direct delivery of patient care. N.J. Admin. Code § 8:31B-3.21; N.J. Admin. Code § 8:31B-4.32. Indirect patient care costs are comprised of institutional overhead expenses such as costs associated with the management, educational, research and maintenance functions.

Medicare shift and payor differentials granted to various payors in 1992. Each of these add-ons or surcharges are described below.

THE SURCHARGES

Hospitals in New Jersey are prohibited from denying admission to patients on the basis of their inability to pay. See N.J. Admin. Code § 8:43G-5.2(c). Patients have the right to "treatment and medical services without discrimination based on race, age . . . diagnosis, *ability to pay*, or source of payment." N.J. Admin. Code § 8:43G-4.1(a)(2). To compensate hospitals for indigent patients and bad debts incurred, referred to as "uncompensated care," a surcharge was added onto the DRG Base Cost. N.J. Admin. Code § 8:31-3.41; 8:31-7.1. This surcharge added 19.1% to a hospital bill to pay for mandated care to the uninsured in 1992. This uncompensated care add-on was collected by each hospital and forwarded to the New Jersey Health Care Trust Fund, which then redistributed the money to hospitals state-wide based upon the amount of uncompensated care costs incurred by each individual hospital.

According to the *Report of the Governor's Commission on Health Care Costs* (the "Governor's Report"), uncompensated care costs increased from $288 million in 1983 to $700 million in 1990. The uncompensated care surcharge to each hospital bill was 19% for the first half of 1990. Notably, this report characterized this add-on as a "tax" to subsidize the social program of providing care to the poor.

In addition to the uncompensated care add-on, each hospital bill included a 7% add-on to compensate hospitals for the "Medicare cost shift." Under the federal Medicare program, hospitals are reimbursed money by the federal government for services provided to Medicare patients. However, pursuant to the administration of the Medicare program, see 42 U.S.C. § 1395(c) *et seq.*, New Jersey hospitals are reimbursed for the care provided at a lower rate than the New Jersey DRG rate. Thus, included in the DRG rate is a "Medicare cost shift" that forced other hospital payors to underwrite the shortfall between the DRG rate and the rate of reimbursement from Medicare. N.J. Admin. Code § 8:31B-3.73.

The third cost-shifting mechanism under the DRG rate systems involves "payor differentials," or discounts, in payment rates available to certain classes of payors. These discounts were offered to payors who demonstrated "quantifiable economic benefit" to the health care system. N.J. Stat. Ann. § 26:2H-18(b) (West 1987 & Supp 1992); N.J. Admin. Code § 8:31B-3.39. Some of the payors that received these discounts were Blue Cross, Blue Shield and HMO's. For example, Blue Cross received an 11% discount because of its open enrollment policy. However, due to restrictions imposed by ERISA, the Welfare Funds must limit their enrollment and are thus prohibited from receiving this discount.[7] None of the Welfare Funds were granted such a discount. Discounts had been

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[7] Notably, however, several of the ERISA plans provide open enrollment within the category of workers and their families eligible to participate in the plan under ERISA.

granted to most, if not all, classes of payors except commercial insurers and self-funded payors such as the Welfare Funds.

As a result of the discounts offered to certain payors, a surcharge was levied on the remaining payors to offset revenue losses generated by the payor discounts. N.J. Admin. Code § 8:31B-3.39. Thus, the Welfare Funds paid much higher fees in order to make up for the discounts offered to other payors.[8]

THE PATIENT APPEAL POLICY

The hospital rate-setting regulations contained an appeal mechanism under which uninsured patients, but not insured patients or third-party payors, could obtain relief from the excessive DRG charges. All *non-insured* patients whose DRG bill exceeded their actual medical costs by greater than $250 (95% of all non-insured patients) could appeal their bill for a reduction to the Total Charges amount.[9] Greater than 99 percent of all such appealed bills were reduced to the actual medical costs incurred by the patient. Because participants in the Welfare Funds were ineligible to appeal, the Welfare

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[8] The Welfare Funds, although non-profit entities, were categorized with commercial profit-making insurance carriers as not entitled to a discount for providing a socially useful purpose, despite satisfying similar criteria as other payors receiving discounts.

[9] The number of uninsured persons in New Jersey is currently estimated at one million. Although not all of these persons availed themselves of the appeal process, each had the right to do so.

Funds again subsidized the system by underwriting the lower payments made by uninsured patients. This conflicts directly with the express terms of the plans that prohibit them from paying benefits in excess of such charge as would have been made in the absence of the Welfare Plan insurance. Thus, if petitioners' trustees abided by the express limitation, a participant would be liable for all excess charges billed (the differential between the DRG rate and the Total Charges) but would be barred from appealing the higher billing rate. On the other hand, if petitioners' trustees paid the full DRG charge, they would have violated the express terms of their plan and would face potential liability for wasting assets. 29 U.S.C §§ 1002 and 186.

During the pendency of this action, some of the Welfare Funds placed the disputed portion of each participant's hospital bill payment into escrow. Other Welfare Funds paid the entire bill under protest, expressly reserving their right to reimbursement. Several complainants, although not all, assert claims for reimbursement of these funds paid under protest or placed in escrow.

THE DISTRICT COURT'S DECISION

The District Court permanently enjoined the State from enforcing the provisions of the hospital billing scheme which added the challenged surcharges to the hospital bills of ERISA participants. In its opinion, the District Court found several distinct grounds for ERISA preemption under the "relates to" test established by the Supreme Court, holding that the statutes and regulations had both direct "references to" ERISA plans and had a

"connection with" such plans. In particular, the Court found that the hospital billing scheme forced the Welfare Funds to structure their benefits in a particular manner; prevented the Welfare Funds from providing full coverage of hospital bills, thus interfering with the express purpose of the Welfare Funds; subjected the funds to inconsistent state regulation interfered with the administration of fund benefits; forced the funds to incur substantial costs for the benefit of non-members in direct violation of ERISA; interfered with the relations among the principal ERISA entities; interfered with the calculation of plan benefits and interfered with a participant's right to appeal a bill by mere virtue of his membership in the plan.

With regard to the Welfare Funds' claims for reimbursement of bills paid to hospitals under protest, the District Court declined to exercise jurisdiction, stating that it believed that these claims were state court common law claims which should be handled in the state courts.[10]

THE COURT OF APPEALS' DECISION

On May 14, 1993, the Court of Appeals in a 2-1 decision reversed the District Court's judgment and held that the challenged portions of New Jersey's rate setting statute were not preempted by ERISA and thus were constitutional, substantially relying upon *Rebaldo v.*

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[10] The Welfare Funds contest this conclusion. These claims for reimbursement constitute federal claims under ERISA and should have been decided by the District Court.

Cuomo, 749 F.2d 133 (2d Cir. 1984). In so holding, the majority opined that the challenged law was not expressly intended to regulate ERISA plans, was "generally applicable," and constituted an exercise of traditional state police power. (19a-32a).

Judge Nygaard dissented on the basis that the questioned portions of the rate setting law refers to ERISA plans, diverts enormous sums of money from ERISA plans, and is predicated upon the existence of ERISA Plans. Accordingly, Judge Nygaard opined that the rate setting scheme "relates to" ERISA in much more than a tenuous, remote or peripheral manner and therefore should be preempted. (44a). Judge Nygaard found that ERISA plans played a critical role in the rate setting scheme to the extent that without ERISA plans the entire rate setting system would "fall apart" since the plans constituted a major segment of the payors of hospital charges in New Jersey. (34a). Judge Nygaard also found that the challenged surcharges were not indirect costs associated with services provided to welfare plan beneficiaries, rather the charges represented the direct cost of hospital services rendered to other patients. (42a). Finally, Judge Nygaard expressed a fear that "the majority gives states free reign to spend and experiment with ERISA Funds, held in Trust for the many members who have labored long for their security, in the noble pursuit of health care reforms so long as States exercise a minimum degree of imagination by couching their statutes in 'generally applicable' terms." (44a).

REASONS FOR GRANTING THE WRIT

I. IN THIS CASE, THE THIRD CIRCUIT COURT OF APPEALS HAS DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW IN A WAY THAT CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT INTERPRETING THE BREADTH OF PREEMPTION PROVIDED BY CONGRESS IN ERISA

The Supremacy Clause of the United States Constitution provides: "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land . . . , any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const., Art. VI. cl. 2. Under this preemption doctrine, a state law must give way to Congressionally enacted statutes where the state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67-68 (1941).

"ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983). To this end, ERISA contains one of the broadest preemption provisions ever enacted by Congress in Section 514(a), 29 U.S.C. § 1144(a):

> except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b).

The Third Circuit's decision in this case conflicts with several recent pronouncements by this Court with respect to ERISA's broad preemption clause.

This Court has consistently ruled that Congress expressly provided a "broadly worded preemption provision in a comprehensive statute," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, which "is conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). "Its deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern." *Ingersoll-Rand*, 498 U.S. at 138. See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). As discussed by this Court, the legislative history supports an expansive construction of ERISA's preemption effect. *Shaw*, 463 U.S. at 98-99, n.20; *FMC Corp.*, 498 U.S. at 58-59.

The key to interpreting the breadth of ERISA's preemption clause are the words "relate to".

> Congress used those words in their broad sense, rejecting more limited preemption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA'.

Ingersoll-Rand, 498 U.S. at 138 (quoting *Shaw, supra*, 463 U.S. at 98). With regard to this broad intent, this Court has defined the phrase "relate to" in the context of ERISA's preemption clause by stating:

> A law "*relates to*" an employee benefit plan . . . if it has a connection with or reference to such a plan.

Shaw, 463 U.S. at 96-97. (emphasis added).

> Under this "broad common sense meaning," a state law may "relate to" a benefit plan, and thereby be preempted, *even if the law is not specifically designated to affect such plans, or the effect is only indirect.*

Pilot Life, 481 U.S. at 47 (emphasis added). See *Ingersoll-Rand*, 498 U.S. at 139; *Alessi*, 451 U.S. 525; *Shaw*, 463 U.S. at 98. ERISA's preemption clause distinctly applies to state laws dealing with matters not themselves covered under the ERISA statute. *FMC Corp.*, 498 U.S. at 58-59; *Ingersoll-Rand*, 498 U.S. at 139. Moreover, ERISA preempts a state law even if the law is "consistent with ERISA's substantive requirements," *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) or the law was enacted to "effectuate ERISA's underlying intent." *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825 (1988).

Notwithstanding these guiding principles developed and consistently upheld by this Court, the majority below held that ERISA's broad preemption clause does not apply to a State law which refers to ERISA plans, extracts enormous amounts of money from ERISA trust funds, and is predicated upon the existence of ERISA plans. Aside from conflicting with the general principles of preemption cited above, the majority's decision particularly conflicts with two recent cases decided by this court – *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). In both of these cases this Court reiterated its broad and expansive reading of ERISA's preemption clause.

In *FMC Corp. v. Holliday, supra*, this Court held that ERISA preempted a Pennsylvania anti-subrogation statute, despite the fact that the challenged State law was

generally applicable and did not single-out ERISA plans. In that case, a self-funded ERISA plan, after paying a portion of a participant's medical bills related to an automobile accident, attempted to recover its payments under a subrogation clause set forth in the plan from a participant who had recovered damages in a negligence action arising out of the accident. The State statute prohibited recovery by any payor seeking to enforce a right of subrogation. In holding that the law was preempted, this Court reasoned that the preemption clause was not solely intended "to preempt only State laws specifically designed to affect employee benefit plans" and also was not solely intended to only preempt State laws dealing with "reporting disclosure, fiduciary duties" and other directly-regulated ERISA concerns. 498 U.S. at 58. The Pennsylvania law was preempted because it incidentally prohibited ERISA-covered plans "from being structured in a manner requiring reimbursement in the event of recovery from a third party." 498 U.S. at 60. Thus, the Pennsylvania law would require plan administrators to structure their benefits in Pennsylvania differently from benefits offered in States which did not have a similar anti-subrogation statute.

Similarly, in the present case, the New Jersey statute required the Welfare Funds to structure their benefits in a particular manner by forcing funds to pay for surcharges solely dedicated to the direct cost of hospital services provided to other patients who are not beneficiaries of the ERISA plan. The funds must either pay the surcharges and violate their express purpose, or restructure their benefits to exclude the surcharges. Accordingly, in a State that does not have a similar statutory scheme of cost-

shifting surcharges, the Funds could cover 100% of the hospital charges, while in New Jersey the Funds must restructure their benefits to pay significantly less than the full charge. As stated by Judge Nygaard, "This is the precise reason why Congress enacted such a broad pre-emption provision: so that employee benefit plans would not be subject to the vagaries of state regulations." (39a).

Although the majority did mention *FMC Corp. v. Holliday, supra,* in a footnote (28a), it otherwise did not follow its holding. In analyzing the impact of the surcharges in subjecting ERISA plans to differing obligations from state to state, the majority simply compared the surcharges to minor increased overhead costs occasioned by a myriad of State regulations governing such areas as utility rates, wage standards and waste disposal, and completely failed to address or even mention the actual impact of the charges upon the petitioners:

> New Jersey's scheme may increase the charges billed to ERISA plan participants for hospital services. This will mean that for any plan which commits to pay all or some lesser percentage of a participant's hospital costs will be called upon to pay more in benefits than it otherwise would. This effect is not different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e., utility costs, the wages of its employees, waste disposal costs, etc. New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way. Nor does it deprive ERISA plans of any alternative they would otherwise have in these areas. Finally,

> since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

(26a-27a).

New Jersey's hospital surcharges, however, are much more than some "indirect costs" or regular business overhead in several important respects. First, the participants receive no benefit, direct or indirect, from the surcharges. Secondly, the surcharges fall inequitably and disproportionately upon ERISA plans to the extent that the plans and their participants have been asked to pay 40% of the $1.1 billion burden imposed, although their participants comprise only 15% of all hospital patients. No ordinary business would knowingly provide a service to one who could not pay. Indeed, even where bad debt is incurred, it is passed along to all the business' customers. As noted by the dissent:

> These surcharges are not equitably distributed to the general population, or to the State, or to even hospital users, but are placed squarely on the shoulders of commercial insurers and ERISA plans. As a result, they contend that they are forced to subsidize nonparticipant patients with ERISA funds.

(41a-42a). Thirdly, the surcharges are not indirect costs generally arising out of hospital use by all patients, instead the surcharges are solely and directly dedicated to funding the care provided to patients who are not beneficiaries of the ERISA plan. These factors clearly demonstrate that ERISA plans in New Jersey are being

subjected to State regulations which so greatly impact them that they must *restructure* their benefits. This impact alone would dictate that the challenged scheme is pre-empted under *FMC Corp.*

Finally, the proper preemption analysis according to *FMC Corp.*, is whether the State law "affects" the ERISA plan or how plan benefits are structured, and a law which significantly burdens the structuring of benefits cannot be rendered valid simply because plan costs might otherwise vary from state to state. The proper focus of the inquiry under *FMC Corp.* should have been the nature and extent of the actual effect of the State regulation upon the plans' ability to structure benefits. It is obvious that the Third Circuit failed to follow the inquiry prescribed by this Court in *FMC Corp.* in favor of a "state police power" analysis which has long since been rejected.

In *Ingersoll-Rand Co. v. McClendon, supra,* this Court held that a state cause of action alleged in a suit by a discharged employee against his employer was pre-empted because the cause of action was premised upon the existence of an ERISA pension plan. The state court suit alleged a wrongful discharge based upon an employer's purported motive of avoiding payment of pension fund benefits. Because the cause of action was necessarily premised upon the existence of an ERISA plan, it was preempted. 498 U.S. at 145.

Similarly New Jersey's hospital surcharges are necessarily premised upon the existence of ERISA trust funds. As noted in the dissent, ERISA plans played "a critical role in this scheme to the point where without them it would fall apart," (34a), because the burden of paying a

large and disproportionate portion of the surcharges falls upon ERISA plans. "They [ERISA plans] comprise a major segment of the paying hospital service users who subsidize those favored by the Act." (34a). Indeed, New Jersey conceded that the rate scheme would not be viable without the money extracted from ERISA plans because "they represent a major segment of the bill-paying public to the point that it is impossible to devise a viable hospital rate setting scheme if that segment is excluded or exempted from the scheme." (35a). Hence, as concluded by the dissent, "the effect of the Act is to reach into the deep pockets of ERISA Funds." (35a). Deep pockets which are no longer in existence due to the New Jersey Regulatory Scheme.

The enormous financial burden upon petitioners and other ERISA plans paying New Jersey Hospital bills is well-documented in the record on appeal. In order to avoid violating their express purpose, some of the ERISA plans placed the disputed portion of each participant's hospital bill into escrow while others paid the entire bill under protest. Also, several of the complaints filed below sought reimbursement of funds paid under protest. In any event, at stake is the payment of millions of dollars in disputed charges, constituting the "lion's share of caring for the uninsured" according to a report commissioned by the State of New Jersey. The imposition of these charges clearly "relates to" ERISA plans, in the normal sense of the term.

The majority's ruling that the cost add-ons provided for in the challenged statute are too "tenuous" or "remote" because the rate setting scheme is of general application completely ignores and belies the *actual*

impact of the surcharges. First, with respect to a particular bill, the uncompensated care add-on above was last set at 19.1% in 1992. Additionally, each bill included a 7% surcharge to compensate for the medicare shortfall. Finally, an additional surcharge was added to recoup the shortfall resulting from payor discounts – a luxury ERISA plans were not afforded. Thus, more than 26% of a hospital bill in New Jersey was directly utilized to subsidize the social program of providing health care for the uninsured and to recoup losses from Medicare and payor discounts. These surcharges amounted to a $1.1 billion cost-shift which disproportionately falls upon ERISA plans to the extent that 40% of the surcharges are extracted from them. Therefore, the surcharges are necessarily premised upon the existence of ERISA plans. In *Ingersoll-Rand*, the Court reasoned that merely the cost of defending a state cause of action affected an ERISA plan and was thus preempted. Certainly, the millions of dollars in surcharges extracted from ERISA plans under the New Jersey hospital rate setting statute would thus be considered a substantial effect upon an ERISA plan under *Ingersoll-Rand*, and should similarly be preempted.

It is urged that *Ingersoll-Rand* and *FMC Corp.* should have been controlling over the issues presented in this case. The Third Circuit decided this case in conflict with those holdings of the Court interpreting the breadth of preemption under ERISA. Therefore, petitioners request review of the Third Circuit's apparent departure from the well-settled principles laid down by this Court with respect to preemption under ERISA.

II. THE DECISION OF THE THIRD CIRCUIT IN THIS CASE CONFLICTS WITH DECISIONS IN OTHER CIRCUITS

The majority principally relied upon *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984) – a case whose rationale has been effectively overruled by this Court in *Ingersoll-Rand Co. v. McClendon, supra*, and a case which is not followed, even in the Second Circuit. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D. N.Y. 1993)[11]; *General Electric Co. v. New York Dept. of Labor*, 891 F.2d 25 (2nd Cir. 1989). Accordingly, it is respectfully submitted that review by this Court is warranted to maintain uniformity among the circuits.

In *Rebaldo*, the Second Circuit reviewed whether a New York statute regulating hospital charges was preempted under ERISA. The challenged law precluded certain health providers, including ERISA plans, from negotiating discounted rates with hospitals. The rationale of the *Rebaldo* court with respect to preemption began with the definition of "State" provided in ERISA Section 514(c)(2), 29 U.S.C. § 1144(c)(2). The Court reasoned that the term "state," defined as "any agency, instrumentality or political subdivision that purports to regulate, directly or indirectly, the terms and conditions of employer benefits plans" modified and restricted Section 514(a)'s broad preemption provision. *Id.* at 139. Thus, the *Rebaldo* court ruled that under ERISA Section 514(c)(2), a state regulation would not be preempted unless the challenged regulation "purports to regulate the terms and conditions of

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[11] *Travelers v. Cuomo, supra*, is currently on appeal before the Second Circuit, No. 93-7194 and was argued on May 20, 1993.

employer benefit plans." As noted by the majority, this specific holding was overruled as a result of *Ingersoll-Rand, supra*. However, it is respectfully submitted that what may have remained of the holding in *Rebaldo* – which is substantially relied upon by the majority – is also no longer viable and has been rejected in many circuits.

Aside from *Rebaldo* being based upon the Section 514(c) rationale expressly overruled by this Court, the *Rebaldo* court further justified its holding on a traditional state police power analysis. Hence, a statute is not pre-empted, according to *Rebaldo*, where the challenged state regulation involves a traditional exercise of generally-applicable state regulatory power, even though the exercise of that power has indirect economic impact upon an ERISA plan. Under recent Supreme Court decisions, this rationale is no longer viable. This argument was apparently raised in *Ingersoll-Rand* and was not even considered by this Court. Likewise, this rationale has been expressly rejected in other circuits. *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991); *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Insurance Association*, 771 F. Supp. 771 (E.D. La. 1991). As held by the District Court of the Northern District of Georgia:

> *Rebaldo* pre-dates the *Metropolitan Life* decision in which the Supreme Court reiterated that *indirect* impact on an employee benefit plan brings a state statute within the scope of ERISA preemption. (emphasis added).

General Motors Corp. v. Caldwell, 647 F. Supp. 585, 588 (N.D. Ga. 1986).

Moreover, the Second Circuit itself has completely abandoned what may have remained of the *Rebaldo* holding. In *General Electric Co. v. New York State Dept. of Labor*, 891 F.2d 25 (2nd Cir. 1989), the Second Circuit held that a New York statute requiring employers on public work projects to pay fringe benefits or the cash equivalent in accordance with prevailing area standards was preempted by ERISA. Although the questioned law was a "generally applicable" statute involving a well-established area of traditional state police power, specifically local labor standards and working conditions, the Court nevertheless ruled that the statute was preempted because it indirectly burdened ERISA plans. This indirect burden was in the form of increased administrative costs to ERISA plans incurred as a result of the statute's record keeping requirements. Thus the holding of *Rebaldo* to the extent that it upheld "generally applicable" State laws having indirect impact on an ERISA plan was implicitly overruled.[12]

Lower Courts within the Second Circuit have expressly held that *Rebaldo* is no longer persuasive or viable. In *Travelers Insurance Company v. Cuomo*, 813 F. Supp. 996 (S.D. N.Y. 1993), the District Court held that a similar New York scheme of surcharges on hospital bills was preempted, and expressly held that *Rebaldo* was no longer good law. *Id.* at 1005. Likewise in *United States Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S.2d 851 (N.Y. Sup. Ct. 1991), *Rebaldo* was also rejected.

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[12] Of note is that Judge Van Graafeiland of the Second Circuit authored both *Rebaldo* and *General Electric*.

Accordingly, petitioners respectfully urge the Court that review of the issues raised in this case is warranted to address the conflict which exists among the Circuits concerning the breadth of preemption under ERISA, and maintain uniformity in this important area of Federal law.

III. THE DECISION BELOW WILL PROVIDE STATES WITH THE UNBRIDLED ABILITY TO SPEND ERISA TRUST FUNDS TO PAY FOR ALLEGED HEALTH CARE REFORM, SO LONG AS THEIR STATUTES ARE DRAFTED IN "GENERALLY APPLICABLE" TERMS – A RESULT WHICH CONGRESS CLEARLY INTENDED TO PREEMPT

Judge Nygaard's dissent aptly expressed the erosion of the ERISA preemption doctrine through the majority's decision, and foreshadows the pilfering of ERISA trust funds by states to pay for health care programs:

> I fear that the majority gives States free reign to spend and experiment with ERISA funds, held in trust for the many workers who have labored long for their security, in the noble pursuit of health care reforms so long as States exercise a minimum degree of imagination by couching their statutes in "generally applicable" terms.

(43a-44a).

It is respectfully suggested that in light of the issue of health care reform being at the top of many states' political agendas, that the majority's decision will cause the states to run roughshod over ERISA plans in their zeal to reform. Reform that, as the dissent notes, is inequitably funded by ERISA plans and not from the States' own general funds. Pursuant to such "reform" initiatives, the demise of ERISA plans is self-evident. This issue alone

illustrates the exceptional importance of this case thus warranting review by this Court.

Petitioners agree that ERISA funds are not entitled to a "charmed existence" in which minor, peripheral or tenuous costs such as those associated with regulated electric bills, road and bridge tolls would be preempted. However, petitioners, under the majority's ruling, certainly do not lead a "charmed existence" under a rate-setting system that extracts hundreds of millions of dollars in fees solely and directly dedicated to the benefit of individuals who are not beneficiaries of ERISA plans. Petitioners do not contend that they are only liable for the direct costs of medical care; and petitioners have not invoked the principle of ERISA preemption to avoid any cost – however peripheral, or tenuous – which might be regulated via State action. Indeed, petitioners have not challenged the base DRG rate system which by its very nature includes costs other than those associated with direct patient care. Petitioners simply submit that New Jersey's hospital rate surcharges, which inequitably forced ERISA plans to fund a large part of the burden of paying for health care to the uninsured, is precisely the State regulatory scheme Congress intended to preempt – a scheme which has an enormous economic impact upon ERISA trust funds, and which clearly requires ERISA plans to structure their benefits in a certain manner.

New Jersey's rate setting laws and regulations refer to ERISA plans, are premised on the existence of ERISA plans, and most importantly, extract millions of dollars from ERISA trust funds. The progeny of the majority's decision in not only New Jersey, but in all states, could be the demise of ERISA trust funds. Petitioners urge the

Court to consider the ultimate impact of the Third Circuit's decision which at worst, threatens the very existence of ERISA plans, and at the very least, completely undermines and eviscerates the purpose of preemption intended by Congress.

CONCLUSION

It is respectfully requested that the Court grant the petition for a writ of certiorari to address the Third Circuit's departure from decisions of this Court concerning the breadth of preemption under ERISA, to resolve conflicts among the circuits, and to remedy the erosion of the preemption intended by Congress.

Respectfully submitted,

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